Allow up to 2 Hours for Appointment

Consult

Appt Date: _____

Appt Time: _____

"Since 1982"
CRUZ Life CENTER

Natural Health Care Solutions for Your Life

- LASER THERAPY
- CHIROPRACTIC
- HEALTH COACHING

Child's Health History

Name: _____ Date_____
Parents/Guardians_____
Address_____ City/State_____ Zip_____
Home Phone_____ Parent Work Phone/s_____
Birthdate_____ Other Children Names/Ages_____
_____
Who Referred You to Us? _____
Past Chiropractic Care? Yes/No Dr.'s Name/Location _____
_____
Current Primary Doctor_____
Current Drugs/Medication_____
Reason For Consulting This Office _____
_____

Please list the number of doses of antibiotics your child has taken in the last 6 Months: _____
Date of last vaccination: _____

Please list any medications your child is taking and for what reason: _____
_____

Birth Intervention: _____ Forceps, _____ Vacuum Extraction,_____ C Section.

Are there any genetic disorders or disabilities that you know of? _____

FEEDING HISTORY: Breast Fed? _____ Yes, _____ No, How Long?: _____

Formula Fed: ___ Yes, ____ No, How Long?: _____ Cows milk fed at _____ months.

List any allergies you know of: _____

According to the National Safety Council, 50% of children fall from a high place in the first year of their life (bed, changing table, chair, steps, car accidents, etc.)
Has this happened to your child? _____ Yes, _____ No, How? _____

Has your child ever been seen on an emergency basis: _____ Yes, _____ No, When: _____
Please list any other trauma not covered: _____

Please check any that apply

Any illness during pregnancy? Explain:_____
Drugs/Medicine/Tobacco/Alcohol in pregnancy? _____
Laborer chemically induced? _____
Pulling or twisting during delivery? _____
Forceps/Vacuum Extraction/C-section? _____
Premature Delivery? _____
Vaccinations? _____
Jaundice treatment? _____
Colic? _____
Eating or nursing problems? _____
Sleeping problems? _____
Falls in first year of life? _____
Other falls or injuries? _____
Respiratory problems? _____
Ear infections? _____
Allergies/Asthma? _____
Digestive problems? _____
Hyperactivity? _____
Poor Nutrition? _____
Auto accident or Injury? _____
Sports injury? _____
Family/home stress? _____
Prescription drug use? _____
Non-prescription drug use? _____
Ever Hospitalized? _____
Surgery? _____
Any major illness? _____
Reoccurring illnesses? _____
Limited Exercise? _____
Any other health related problems? _____

Anything else? _____

_____

_____

PAYMENT INFORMATION

Do you have health insurance? Yes_____, No_____

PLEASE NOTE: The cost of your exams and x-rays are to be paid on the day of service. Please give the receptionist your insurance card so we can make a copy.

Will you be paying with: Cash _____, Check _____, Credit card _____

I request that financial arrangements be made for payment _____

WE ACCEPT PAYMENT BY CASH, CHECK, AND CREDIT CARD

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

Signature_____ **Date**_____

WE WILL DO OUR BEST TO NOTIFY YOU OF ALL POSSIBLE COSTS BEFORE PROCEEDING.